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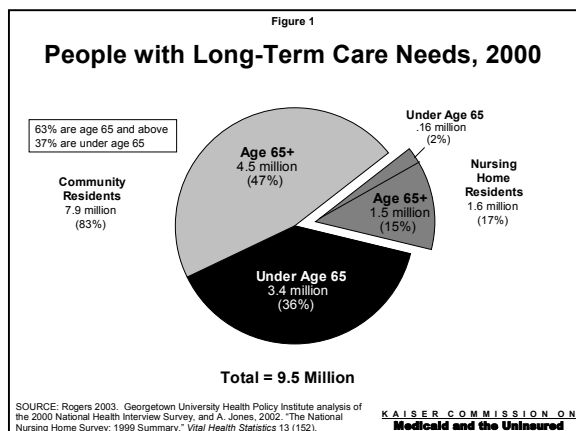
Medicaid and Long-Term Care

Medicaid is the nation's major source of financing for long-term care services, covering long-term care services for both elderly and non-elderly persons in institutional settings and in homes and other community-based settings. Many of these critical services are not covered by Medicare or private insurance. However, Medicaid's long-term care protections are limited to those with low-incomes or who incur catastrophic expenditures.

Who needs long-term care?

Nearly 10 million Americans need long-term care services and supports to assist them in life's daily activities (Figure 1). Long-term care involves providing a range of supportive services that may assist individuals with performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs). These range from providing assistance with eating, dressing, and toileting, to assisting with managing a home, preparing food, and medication management.

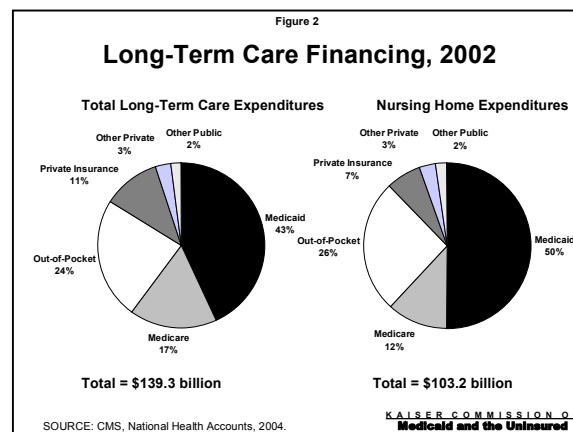
For some people, these are lifetime needs. Children born with severe physical impairments, developmental disabilities, or a degenerative disease often need care throughout their lives. Teenagers and adults who incur traumatic injuries may need care for decades. The elderly often need some long-term care service due to decreasing mobility and cognitive functioning that comes with aging and often more extensive services for those disabled by a serious illness.



Who pays for long-term care?

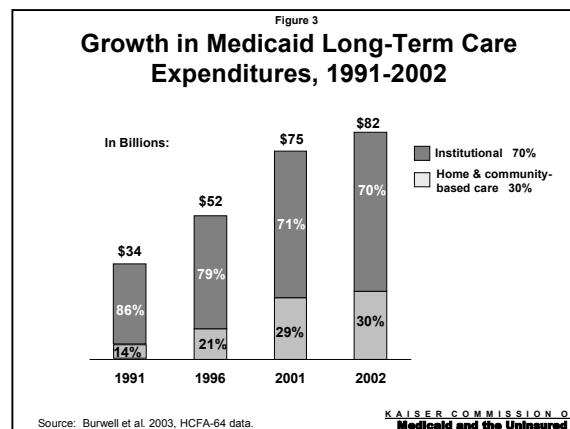
Although many people who need long-term care rely primarily on informal help from family and friends, almost \$140 billion was spent on long-term care in 2002

(Figure 2). Medicaid accounted for 43% of long-term care services (\$60 billion). Direct out-of-pocket spending comprises the next largest payer category, accounting for almost one-quarter, or \$33 billion, in spending. Medicare provides limited post-acute care through its skilled nursing facility benefit and its home health care benefit, accounting for only 17% of spending.



Medicaid and long-term care

Although Medicaid assists more persons with long-term care needs in their homes or communities (2 million) than in institutions (1.5 million), spending on long-term care services is weighted toward institutional care. In 2002, 70% of Medicaid long-term care spending was for institutional care. Spending on Medicaid home and community-based care is growing (Figure 3). In 2002, this care accounted for 30% (\$25 billion) of total Medicaid long-term care spending up from 15% (\$6 billion) in 1992.



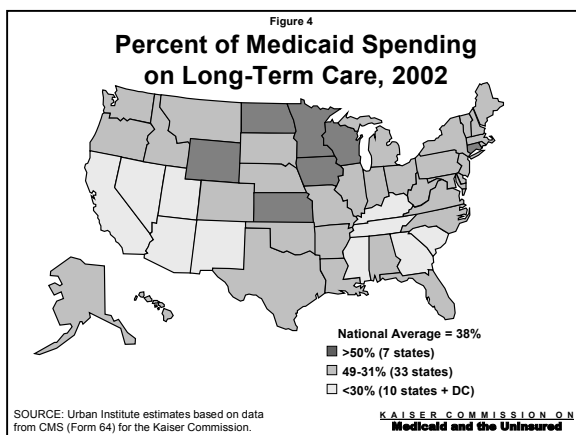
Medicaid is not available to everyone who needs long-term care. To limit public expenditures, those who need long-term care must meet financial and categorical eligibility criteria to qualify for Medicaid. For the elderly and people with disabilities with long-term care needs, these limits are often tied to the Supplemental Security Income (SSI) program—\$564 per month in 2004 – but states can, and often do, set higher limits.

Most states also allow the “medically needy” --those with high medical bills--to spend down to a state-set eligibility standard. In addition, because few people can afford the high cost of nursing home care, 33 states allow individuals needing nursing home care to qualify under the “300 percent rule”. Under this option, individuals with income up to 300% of SSI (\$1,692 per month in 2004) can qualify for Medicaid assistance with institutional care. Nursing home residents who qualify as medically needy or through the 300 percent rule must apply the majority

of their monthly income toward the cost of care, except for a small personal needs allowance. Those with spouses living in the community are allowed to disregard a certain amount of income for the support the community-residing spouse. Medicaid beneficiaries receiving home and community-based services are also required to apply a portion of their income to the cost of care; states are not required to offer spousal impoverishment protections to waiver participants.

State variation

States have considerable flexibility to set eligibility levels, determine which services will be covered, and to set payment rates, with important consequences for who gets access to services. Spending on long-term care varies greatly across states -- long-term care accounts for more than 50% of Medicaid spending in 7 states, and less than 30% in 11 states (Figure 4).



States also vary in the extent to which they cover community-based long-term care. In some states, a

significant share of resources is devoted to home and community-based care. Expenditures for home and community-based care range from 11% of total Medicaid long-term care expenditures in Louisiana to 63% in New Mexico.

Issues in Medicaid long-term care

Medicaid is the single largest source of financing for long-term care and accounts for the vast majority of public financing, however, there are a number of concerns about how the program works and a number of ways in which Medicaid long-term care could be improved to expand access to care and the quality of the services provided.

Eligibility for assistance. Few Americans have insurance to protect them from the high cost of long-term care. Medicaid is usually the only source of financial assistance, but eligibility is limited to the very poor or those with high expenses. Many elderly persons enter nursing homes as private pay clients, spend their available life savings, and become eligible for Medicaid once they have depleted their assets. In some cases, this process can be demeaning and burdensome and can result in foregone or delayed assistance for those with long-term care needs.

Access to community-based care. All states are required to provide institutional services, but are generally not required to provide home and community-based services. Since states often provide community-based services as optional benefits or through waivers, eligibility, enrollment and funding have been limited. Many thought the *Olmstead* decision would lead to a rapid expansion of community-based services, but the recent fiscal crisis has been a barrier to increasing access to community-based services in many states. Consequently, many states have long waiting lists for home and community-based waiver services.

Financing and quality. The need for long-term care is projected to increase due to the growth in the under-65 disabled population as well as the aging of the population. At the same time, quality concerns about care in nursing homes and community-based settings persist. In the absence of broader reform, efforts to assure that Medicaid can continue to finance long-term care coverage for the low-income population, increase the availability of community-based care, and develop better quality-monitoring systems are fundamental to Medicaid’s role as the nation’s major source of long-term care financing.

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